

endocarditis], prophylaxis for dental procedures may be reasonable, even though its effectiveness is unknown".¹⁴

Additional prophylactic measures for infective endocarditis include education of at-risk patients about the need for meticulous dental and skin hygiene and avoidance of unnecessary invasive procedures (eg, intravenous cannulae, urinary catheters). Strict adherence to institutional hygiene is crucial—a third of cases of prosthetic valve or *S aureus* infective endocarditis are nosocomial in origin and mortality in this setting exceeds 30%.^{18,19} Early diagnosis is assisted by a high index of suspicion for the possibility of infective endocarditis and avoidance of antibiotic treatment without blood cultures in the event of unexplained febrile illness affecting high-risk patients.

Practices for prophylaxis of infective endocarditis seem set to change. New guidelines aim to provide simple, unambiguous protocols for everyone involved in the care of those few patients at risk of the disease. Consensus on their implementation is needed to avoid confusion in the minds of health professionals and, most importantly, patients.

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Public-health crisis after the election violence in Kenya

When the centre cannot hold, things fall apart

*Chinua Achebe, Nigerian novelist and poet,
from his 1958 book, Things fall apart*

After the disputed Presidential poll outcome of the Dec 27, 2007, elections, violence erupted in various parts of Kenya and led to deaths, injuries, massive displacements of people, and increased insecurity. Anger over the election outcome quickly translated into civil unrest over economic inequalities, land grievances, and

ethnic animosity. Simultaneously, property was destroyed on an unprecedented scale, and transport, health services and research, and public services were disrupted.¹ At least 1000 people might have died (from mortuary counts) and more than half a million have been displaced from their homes.² Because many bodies were buried without compliance with legal procedures (eg, admission to a mortuary) or disposed of unconventionally (eg, mass burial or into pit latrines), these numbers might have been grossly underestimated.³

The printed journal includes an image merely for illustration

Reuters

A woman waits to identify relatives killed by postelection violence in Eldoret, Kenya

The disaster disrupted the coordination and delivery of both routine and emergency health services in the affected districts. Medical and health-research staff in the most affected areas were among the displaced, and those available could not access their workplace because of insecurity and disruption in public transport. Even when transport was available, some health workers had restricted access to patients because they feared ethnic-related attacks. It is especially important in these circumstances for health workers to act ethically, upholding their professional obligation to provide impartial service to patients. About 30% of health facilities in the affected areas became non-functional.² Specifically, these facilities faced severe strain because of inadequate numbers of staff and lack of essential supplies of drugs, blood for transfusion, resuscitation equipment, intravenous fluids, and suture materials.⁴ Consequently, trauma victims died of injuries that under normal circumstances and reasonable access to medical services could have been treated. With a disrupted health system, the central Ministry of Health had insufficient local capacity to respond to the disaster, which resulted in an inadequate surveillance system and poor coordination. In the meantime, several health partners, including non-governmental and international humanitarian groups, undertook rapid situational assessments and disaster management, albeit with poor coordination.²

About half a million people were internally displaced or had acquired refugee status in neighbouring

countries; of those internally displaced, about 75% were women and children.² The living conditions in the makeshift camps are pathetic, with poor sanitation, outbreaks of communicable diseases, inadequate water and food supplies, and sexual abuse.^{5,6} The disrupted access to basic health services (preventive and curative) adversely affected those with chronic diseases who needed replenishment of medications (eg, drugs for tuberculosis, hypertension, diabetes, and antiretrovirals) and those in need of reproductive and maternal and child health services (eg, immunisation and antenatal care).^{2,4} There were sporadic reports about gender-based violence.⁷ Presently, there is an urgent need for counselling services for victims of psychosocial trauma. Without a data-collection system, we have missed an opportunity to monitor and assess the health situation.

After the outbreak of violence-related deaths, public mortuaries were starkly neglected, which led to worsening of already deplorable conditions of storage and preservation. In Kenya, as in many other developing countries, mortuary premises are relatively underdeveloped, underfunded, and poorly staffed compared with other service-providing units within the health system. These difficulties are compounded during a humanitarian disaster when the number of dead bodies admitted to these facilities increases several fold. During the first 4 weeks of January, 2008, the capacity of public mortuaries in the violence-affected areas was overstretched; mortuaries were managing up to five times their usual capacity at the peak of the violence.³ Additionally, mortuary premises had inadequate interventions to prevent psychological trauma, chemical pollution, and risks of infectious diseases, which made these premises occupationally unsafe and potentially unhealthy for staff and bereaved families. For most bodies, post-mortem examinations were almost never done to identify the cause of death because of the acute shortage of forensic pathologists and supplies. Poor preservation of bodies made it difficult to identify and maintain evidence. Partly due to overcrowding in the mortuaries, unclaimed bodies were disposed of without collection of specimens that might aid future identification—eg, fingerprinting or tissue sampling for DNA analysis.³ Public health laws and policies that aim to improve the quality of mortuary facilities and services need urgent revision.

The postelection violence in Kenya resulted in many deaths and displacement of many people, but it has also revealed a weakness in the country's strategy for emergency preparedness and the need to improve mortuary services. The crisis posed a challenge to the ethics of health research, and now health and research institutions have to respond with integrity to restore respect for human beings and a return to harmonious coexistence among health workers. A study of the intermediate and long-term effects of the conflict on health would be informative.

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Do classical origins of medical terms endanger patients?

To improve safety, many people recommend that health care replicates the efforts of high-reliability industries—ie, those that regularly avoid disasters in complex risk-prone environments—such as aviation or nuclear power.¹ To achieve this goal there is an implicit need to embrace industry's awareness of communication-related errors, willingness to apply predictive safety techniques, and ability to reform jargon.

The communication system of the aviation industry was specifically formulated to avoid look-alike or sound-alike terms (eg, the differences between “foxtrot” and “sierra” of the NATO phonetic alphabet are clearly audible compared with those of “f” and “s”).² Many medical terms originate as far back as the 5th century BC, but are used to name 21st-century high-tech concepts used in noisy, stressful, and time-limited situations. Because the limited vocabulary of dead languages is reused and recycled within the same classical structure, there are many look-alike and sound-alike terms. For example, a review of *Black's Medical Dictionary*³ predicts a number of prefixes that could be used to form high-risk, sound-alike, or look-alike terms (table).

The medical education system suffers enormous pressures to deliver increasingly more in less time⁴ with no obvious reduction in medical jargon. Clinicians can qualify without achieving fluency, or they risk being so embedded in the language that they cannot translate

for patients. And even the most experienced of staff can make mistakes.^{5,6}

The Institute for Safe Medication Practices⁷ has been instrumental in leading change in several areas—by identifying error-prone abbreviations and pairs of look-alike or sound-alike drug names. Although learning from past incidents is a key feature of safety improvement, other industries use predictive safety techniques that review the current terms and create new terms to prevent future problems.

Several international agencies have tried to solve the problem of confusing terminology through global harmonisation of terms. Although lessons from aviation show us that broad-brush harmonisation should be used with caution: when under pressure, pilots abandon aviation English and revert to their mother tongue⁸ and, being practical, patients with identical names on a ward are unlikely to welcome their names being harmonised for our convenience.⁹

Knowing what the problematic terms are, who uses them, and when, how, and why is necessary to identify solutions. The risk for adverse consequences of sound-alike terms is greatest if they are used in time-pressured situations in which there is unfamiliarity with the terms, there is little opportunity to clarify them, and there are high levels of noise and distraction. Unfamiliarity with accents or linguistic idiosyncrasies is another problem especially pertinent to multicultural, mobile workforces.